Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

# PHYSICIAN ASSISTANT & NURSE PRACTICIONER PARAMEDIC PROGRAM COMPETENCY SUMMARY

CANDIDATE'S PRINTED NAME

CANDIDATE'S EMS CERTIFICATION #

**Please ✔ the method(s) below that were utilized for verification of candidate's competency**

| COMPETENCIES | Paramedic Program Required Numbers* | Q/A: Q/I | DIRECT OBSERVATION | OTHER |
|---|---|---|---|---|
| Medication Administration | 15 | ☐ | ☐ | ☐ |
| Oral Intubation (Adult) | 1 Live | ☐ | ☐ | ☐ |
| Intravenous Access | 25 | ☐ | ☐ | ☐ |
| Ventilate Non-Intubated Patient | 1 | ☐ | ☐ | ☐ |
| Adult Assessment | 50 | ☐ | ☐ | ☐ |
| Pediatric Assessment | 30 | ☐ | ☐ | ☐ |
| Geriatric Assessment | 30 | ☐ | ☐ | ☐ |
| OB Assessment | 10 | ☐ | ☐ | ☐ |
| Trauma Assessment | 40 | ☐ | ☐ | ☐ |
| Psychiatric Assessment | 20 | ☐ | ☐ | ☐ |
| Chest Pain Assessment | 30 | ☐ | ☐ | ☐ |
| Respiratory/Dyspnea Assessment | 20 | ☐ | ☐ | ☐ |
| Pediatric Respiratory and Dyspnea Assessment | 8 | ☐ | ☐ | ☐ |
| Syncope Assessment | 10 | ☐ | ☐ | ☐ |
| Abdominal Complaints | 20 | ☐ | ☐ | ☐ |
| Altered Mental Status | 20 | ☐ | ☐ | ☐ |

*****Candidate is not required to meet the specific numbers for each competency but they are listed as a guide for the OMD/PCD utilization during the evaluation.

As Operational Medical Director / Physician Course Director, I do hereby affix my signature attesting to the competency in all of the items outlined above.

Printed Physician Name

OMD/PCD NUMBER

PHYSICIAN SIGNATURE

DATE SIGNED

ALL PARAMEDIC CANDIDATES MUST DEMONSTRATE COMPETENCY AS A TEAM LEADER ON AN ADVANCED LIFE SUPPORT EMS UNIT FOR A MINIMUM OF 50 RUNS.

| Team Leader on EMS ALS Unit | 50 Patient Contacts |
|---|---|

As a Paramedic Preceptor approved by the OMD/PCD on the reverse side, I do hereby affix my signature attesting to the completion of the competency of Team Leader on an EMS ALS Unit on a minimum of 50 patient contacts.

Printer Paramedic Preceptor Name

PARAMEDIC PRECEPTOR SIGNATURE

DATE SIGNED

As Operational Medical Director / Physician Course Director, I do hereby affix my signature attesting to the competency in all of the items outlined above.

Printed Physician Name

OMD/PCD NUMBER

PHYSICIAN SIGNATURE

DATE SIGNED

***If this form is not completed in its entirety it will be returned to the candidate for completion.***

**A copy of this completed form must be forwarded to:**
**ALS Training Specialist**
**Office of EMS**
**109 Governor Street UB-55**
**Richmond, Virginia 23219**